STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted] **2022**
Signature Confirmation

[redacted]
[redacted]
Request # 195530

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted], (the "Appellant") denying services under the Community First Choice ("CFC") program.

On [redacted] 2022, [redacted] (the "Guardian") the Appellant's guardian requested an administrative hearing to contest the denial of CFC services.

On [redacted] 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling a telephonic administrative hearing for [redacted] 2022.

On [redacted] 2022, the Guardian requested the hearing to be rescheduled.

On [redacted] 2022, OLCRAH issued a notice rescheduling the telephonic administrative hearing for [redacted] 2022.

On [redacted] 2022, the Guardian requested the hearing to be rescheduled.

On [redacted], 2022, OLCRAH issued a notice rescheduling the telephonic administrative hearing for [redacted] 2022.

A copy of this decision will be translated in [redacted] and mailed at a later date.

On [redacted] 2022, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, the OLCRAH held an administrative hearing. The following individuals participated in the hearing:

[redacted], the Appellant's Guardian
[redacted] Appellant's Primary Care Physician
[redacted], Interpreter, [redacted]
Eric Bulewich, Social Worker, CFC, Department's Representative
Jose Michael Gonzalez, CFC, Department's Representative
Orenthia Channer, RN, CFC, Department's Representative
Carla Hardy, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly denied the Appellant's request for services under the CFC program.

FINDINGS OF FACT

1. The Appellant is receiving Medicaid. (Guardian's Testimony)

2. The Appellant is [redacted] (DOB [redacted]98) of age. (Exhibit 1: CT DDS Level of Need Assessment and Screening Tool, [redacted]/21)

3. [redacted] is the Appellant's guardian, and mother. (Hearing Record)

4. The Appellant resides with the guardian. (Guardian's Testimony)

5. The guardian is the Appellant's primary caregiver. (Exhibit 1)

6. On [redacted] 2021, the Appellant participated in a reassessment for services with the Department of Developmental Services ("DDS"). The assessment included an evaluation of the Appellant's physical status, mental status, and functional assessment. It also included an assessment of the Appellant's activities of daily living ("ADLs"), instrumental activities of daily living ("IADLS"), and health-related tasks. The evaluation also included an assessment of the Appellant's primary caregivers including voluntary unpaid assistance. (Exhibit 1; Hearing Record)

7. DDS acts as a Medicaid operating partner under a Memo of Understanding with the Department. (Hearing Record)

8. The DDS assessment concluded that the Appellant is independent with dressing, bathing, toileting, eating, mobility, and transferring. (Exhibit 1)

9. On [redacted] 2021, the Community First Choice ("CFC") completed an evaluation which included a detailed assessment of needs related to core ADLs and a review of the DDS assessment because it was completed within the prior 12 months. The DDS assessment does not include a detailed assessment of core ADLs. (Exhibit 2: Universal Assessment, [redacted] 22; Hearing Record)

10. The cord ADLs include bathing, dressing, toileting, transferring, and eating. (Exhibit 2)

11. A social worker with the [redacted] completed a face-to-face interview with the Appellant. The social worker assessed the Appellant's ADL needs. (Hearing Record; Testimony)

12. [redacted] is the Department's contractor for the purpose of assessing the level of care and service needs for CFC. (Hearing Record)

13. [redacted] documented that the Appellant required cueing and/or supervision with bathing and dressing, and was independent with toileting, transferring, and eating. (Exhibit 2: Hearing Summary)

14. The Appellant receives 16 hours of services weekly from DDS. (Guardian's Testimony)

15. The individualized support goals for the Appellant include doing laundry, getting out of the house, applying for a job, and going to the store. (Guardian's Testimony)

16. [redacted]. (the "doctor") has been the Appellant's Primary Care Physician since [redacted] 2021. He sees the Appellant every six weeks. (Doctor's Testimony)

17. The doctor is a primary care physician of internal medicine and a gastroenterologist. (Doctor's Testimony)

18. The Appellant has become withdrawn and depressed. He has lost interest in eating. His weight changed from 109 to 97 pounds. The Doctor has prescribed Megace 40ml/suspension 400mg per day for the Appellant's appetite and Ensure for extra calories. (Doctor's Testimony)

19. The Appellant has difficulty with his gait and balance. He is malnourished and has a vitamin deficiency. (Doctor's Testimony)

20. The guardian confirms that the Appellant is independent with eating and transferring. He requires cueing for toileting. He requires assistance with dressing. He can bathe himself, but she needs to wash his back. (Guardian's Testimony)

21. In [redacted] 2021, the Guardian worked 10 hours weekly outside the home. As of [redacted] 2022, she increased her hours to 32 hours weekly. (Guardian's Testimony)

22. On [redacted] 2022, the Department issued an NOA to the Appellant denying CFC services because he does not have unmet ADL needs and is receiving appropriate supports from DDS. (Appellant's Exhibit C: NOA, [redacted]/22)

23. As of the date of this hearing, the Appellant has a reassessment scheduled with DDS on [redacted], 2022. ("Guardian's Testimony")

24. The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2022. Therefore, this decision is not due until [redacted], 2022. However, the hearing was rescheduled two times causing a 43-day delay. Therefore, this decision is due [redacted] 2022.

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. Title 42 of the Code of Federal Regulations ("CFR") Section 441.500(a) provides that this subpart implements section 1915(k) of the Act, referred to as the Community First Choice option (hereafter Community First Choice), to provide home and community-based attendant services and supports through a State plan.

3. Title 42 CFR § 441.500(b) provides Community First Choice is designated to make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

4. Title 42 CFR § 441.505 provides for definitions and states in part that Activities of daily living (ADLs) means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring. Instrumental activities of daily living (IADLs) means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

5. Title 42 CFR § 441.510 address eligibility for the program as follows:
   To receive Community First Choice services and supports under this section, an individual must meet the following requirements:
   (a) Be eligible for medical assistance under the State plan;
   (b) As determined annually-

(1) Be in an eligibility group under the State plan that includes nursing facility services; or

(2) If in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act; and,

(c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan. The State administering agency may permanently waive the annual recertification requirement for an individual if:

(1) It is determined that there is no reasonable expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity; and

(2) The State administering agency, or designee, retains documentation of the reason for waiving the annual recertification requirement.

(d) For purposes of meeting the criterion under paragraph (b) of this section, individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.

(e) Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities.

6. Title 42 CFR § 441.520 provides for included services as follows:

(a) If a State elects to provide Community First Choice, the State must provide all of the following services:

(1) Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing.
(2) Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.
(3) Backup systems or mechanisms to ensure continuity of services and supports, as defined in § 441.505 of this subpart.
(4) Voluntary training on how to select, manage and dismiss attendants.

7. Title 42 CFR § 441.535 provides for Assessment of functional need. States must conduct a face-to-face assessment of the individual's needs, strengths, preferences, and goals for the services and supports provided under Community First Choice in accordance with the following:
   (a) States may use one or more processes and techniques to obtain information, including telemedicine, or other information technology medium, in lieu of a face-to-face assessment if the following conditions apply:
      (1) The health care professional(s) performing the assessment meet the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology;
      (2) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff; and
      (3) The individual is provided the opportunity for an in-person assessment in lieu of one performed via telemedicine.
   b) Assessment information supports the determination that an individual requires Community First Choice and also supports the development of the person-centered service plan and, if applicable, service budget.
   (c) The assessment of functional need must be conducted at least every 12 months, as needed when the individual's support needs or circumstances change significantly necessitating revisions to the person-centered service plan, and at the request of the individual.
   (d) Other requirements as determined by the Secretary.

8. For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians

practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. Connecticut General Statutes § 17b-259b(a).

The Department correctly determined that the 16 weekly hours of services provided through DDS plus the unpaid family support does not place the Appellant at risk of institutionalization.

Based on the evidence provided, CFC correctly determined that the Appellant does not have any unmet ADL needs.

On [redacted] 2022, CFC correctly denied the Appellant's request for CFC services.

DECISION

The Appellant's appeal is **DENIED.**

Carla Hardy
Carla Hardy
Hearing Officer

Pc: Community Options Unit

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue, Hartford, CT 06105-3725.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.